Released 4/6/00.

FEGLI

Claim for Accidental Means Dismemberment Benefits
Federal Employees' Group Life Insurance Program

Instructions to Claimant

1. General -
To avoid delay:
(a) Read these instructions carefully.
(b) Type or print in ink.

2. Completion of claim -
Part A should be completed by the claimant (usually the insured employee). The claimant should then have Part C on the reverse side completed by the attending physician.

3. Medical and accident reports -
Please attach copies of all medical reports from the first date until the last date of treatment received as a result of the accident. Any police/traffic accident or other accident related reports should be attached.

4. If assistance is needed -
If you need assistance in completing this claim contact the employing office of the department or agency in which you are employed.

5. Where to send claim -
Forward the completed claim to the employing office of the department or agency in which you are employed.

Part A - General Information Concerning the Insured

1. Full Name of the insured *(Last, first, middle)*	2. Date of Birth *(Month, day, year)*	3. Social Security Number

4. Department of agency in which employed, including bureau or division	5. Location of employment (City, State & Zip Code)	6. When did the accident happen? (Month, day, year) 7. Where did the accident happen? (City and State)

8. Give a brief description of the accident (Attach all medical and accident reports as instructed above)

I hereby certify that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld. I also authorize the physician to release any information requested with respect to this claim.

Signature of claimant		Address
Telephone number (day) (evening)	Date	

Instructions to Employing Agency

It is the agency's responsibility to assist the claimant in properly completing this claim. After Parts A and C have been completed, the agency should fully complete Part B and forward the claim to:

Office of Federal Employees' Group Life Insurance
200 Park Avenue
New York, NY 10166-0188

Part B - Certification of Insurance Status

1. Annual rate of basic pay established for basic life insurance purposes on the date of the accident. →	$
2. Was employee covered by Option A - Standard life insurance on the date of the accident? YES ☐ NO ☐ →	Date of election

I certify that the above information has been obtained from and correctly reflects official records and the employee named was covered by Federal Employees' Group Life Insurance on the date of the accident.

Signature of authorized agency official	Name of agency	
Name of authorized agency official (type or print)	Mailing address of agency, including ZIP Code	
Title		
Date	Commercial telephone number Area code	Fax number Area code

Part C - Physician's Statement

1a. Name of patient

1b. Age

2a. Date of accident *(month, day, year)*

2b. Date first consulted on account of injury described *(month, day, year)*

2c. Date of last treatment *(month, day, year)*

3. Describe the exact nature, location, and extent of all injuries sustained. (Attach all medical reports relevant to the treatment of the injury incurred)

4. Was the injury described solely responsible for the loss?

☐ YES

☐ NO → Give the particulars of any cause or causes, including disease, which contributed to the loss.

To Be Completed Only for Limb Amputations

5a. Which limbs were severed or amputated?

5b. On what dates did the severances or amputations occur?

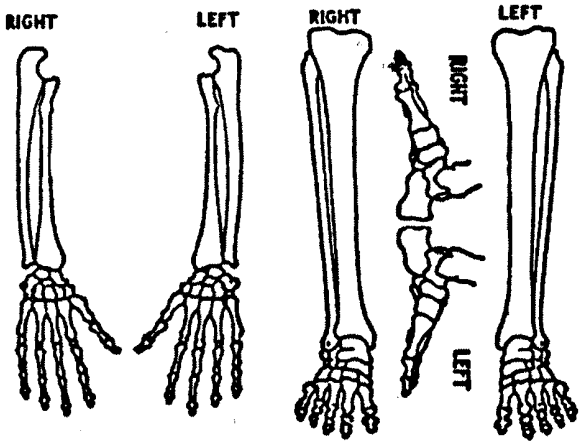
5c. State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

5d. State the causes of the amputations.

6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated, or examined the patient.

7. Please give the names of such other physicians who have attended this patient, and the dates of their first and last treatments as reported to you.

CHART



I hereby certify that all statements made above are true to the best of my knowledge and belief.

Signature of Physician

Date

To Be Completed Only for Loss of Vision

5a. Give the date of exam and vision prior to the accident.

(Snellen) Notations)		Uncorrected	Corrected
	Right Eye		
	Left Eye		

5b. State the loss of vision.

5c. Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

(Snellen) Notations)		Uncorrected	Corrected
	Right Eye		
	Left Eye		

5d. Give the date and vision found on last eye examination

(Snellen) Notations)		Uncorrected	Corrected
	Right Eye		
	Left Eye		

6. Indicate whether recovery of useful vision is possible by operation or treatment.

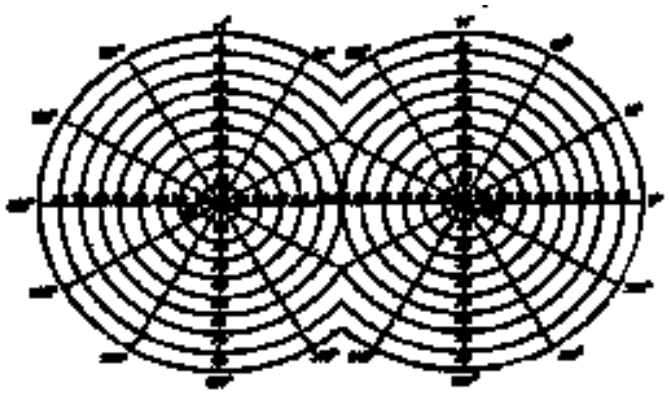
Richt eye Operation ☐ Treatment ☐

Left eye Operation ☐ Treatment ☐

7. If eye is enucleated, give date.

8. If fields of vision are contracted, show contration on chart below.

Left Eye *L.E.* Right Eye *R.E.*



Office Address - Number and Street

City, State and ZIP Code

Telephone number Area code

Fax number Area code